Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

The Utah Department of Health, Division of Health Care Financing, (hereafter referred to as "the Department") will implement, effective January 1, 2001, the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as described at Section 1902(a) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, (H.R. 5661 as incorporated into the Consolidated Appropriations Act, 2001), (PubLNo106-554).

The base encounter rate will be an average of each FQHC's and RHC's fiscal year costs for years 1999 and 2000, adjusted by the Medicare Economic Index (MEI) for each respective year, divided by the total encounters for those same years. The encounter rate will be a blended rate of all service costs (e.g., medical, dental, etc.), exclusive of costs or encounters for carve-out services. Adjustments to the encounter rate will be made in subsequent years by the application of the MEI and any changes in scope as described below.

FQHCs and RHCs will submit annually to the Department their Medicare Cost Report, trial balances, annual independent audit, and other supplementary information as requested and mutually agreed upon, in order to substantiate the fiscal integrity of each FQHC and RHC as a Medicaid contractor.

The Department will provide to each FQHC and RHC on an annual basis notification of the adjusted PPS reimbursement rate and HMO/carve-out encounter and payment data. Additionally, the Department will document the FQHC and RHC Prospective Payment System within the Medicaid Provider Manual, including subsequent amendments.

Scope of Service Changes

FQHCs and RHCs may request, no more than once per quarter, that PPS payment rates be adjusted for any increases or decreases in the scope of service. A change in the scope of service in an FQHC or RHC can reflect the addition or deletion of an FQHC or RHC - covered service or a change in the intensity, duration, amount and/or character of currently offered FQHC services. The Department will review, prior to approval, all requests to ensure compliance to the Medicare FQHC regulations relative to these changes. The review may take place up to one year after the Department allows the change on an interim basis.

Providers must submit the FQHC and RHC Application for PPS Change in Scope which substantiates the changes and the increase/decrease in costs related to these changes, following Medicare principles of reasonable cost reimbursement. The changes must be significant, with substantial increases/decreases in costs, and documentation must include data to support the calculation of an adjustment to the PPS rate. The cost impact must be material and significant: greater than1% of the FQHCs or RHC's per encounter costs.

Scope Change Adjustment Process

1. FQHCs and RHCs, at their initiation, will notify the Department in writing within 90 days of the effective date of any changes in scope of service and explain the reasons for the change. Any adjustment in encounter rate will be effective for services performed after the date of the change in the scope of services.

2. FQHCs and RHCs will submit the FQHC and RHC Application for PPS Change in Scope which substantiates the changes and the increase/decrease in costs, following Medicare principles of reasonable cost reimbursement, related to these changes.

3. FQHCs and RHCs will be notified in writing by the Department within 30 days of any adjustment to the rate following a review of the submitted FQHC Application for PPS Change in Scope.

4. FQHCs and RHCs may appeal the Department's determination for an adjustment or the amount of the adjustment in accordance with the procedural requirements contained in the Medicaid Provider Manual.

5. For changes in scope that occurred in a FQHC's and RHC's fiscal years 2001 and until PPS implementation in 2002, the above described process will apply.

6. The Department reserves the right to adjust the encounter rate for any scope of change that comes to its attention.

Claims Process

Effective April 1, 2002, for RHCs and May 1, 2002 for FQHCs, all medical claims will be submitted on Form HCFA 1500 [CMS 1500] using the encounter code "T1015". Until further notice, claims for dental services will continue to be submitted on the ADA Dental claim form as currently done. PPS will not be effective for dental claims until the Department can perform additional system programming to accommodate the ADA dental form.

HMO Reimbursements

FQHCs are entitiled to, and must be awarded as requested, contracts with HMOs and carve-out service providers. The FQHC will track billings and reimbursements from vendors in order to document the level of wrap-around payment due from the Department to reconcile to the PPS rate. The Department will make quarterly calculation and payment of HMO/carve-out reconciliation.

Rate Determination for New FQHCs and RHCs

Newly qualified FQHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of other clinics, through cost reporting methods. This initial payment will be considered an approximation of the provider's cost and will be adjusted after the first full twelve month cost report is submitted. This first period of operation therefore will be paid based upon an allowable cost basis. Once the first full year cost report has been received and reviewed the PPS rate effective for the provider will be the basis of all future payments. New FQHCs and RHCs lacking actual fiscal reports due to no or limited service delivery will submit the FQHC and RHC Application for PPS Change in Scope. The Department will recognize the capital and other start-up costs documented on the schedule in determining the initial PPS rate. Startup costs will be amortized over an estimated useful life not to be less than five years. Actual costs incurred will be reported at the end of the first year of operation and will form the basis for the calculation of the subsequent PPS rate.

After the initial year, the provider's payment rates shall be adjusted to reflect the change in the MEI.